

**State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020**

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

All persons who are requesting a determination as to whether a CON is required for a proposed project must complete this form. Completed forms should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	Professional Sleep Diagnostics, INC.	
Doing Business As	Sleep Management Serv.	
Name of Parent Corporation	Professional Sleep Diag.	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	PO BOX 20048 Charleston WV 25362 112 Mellon street Beckley WV 25801	
Petitioner type (e.g., P for profit and NP for Not for Profit)	P	
Name of Contact person, including title	SAM J. HELMICK President	
Contact person's street mailing address	35 Pinnacle Drive Charleston WV 25311	
Contact person's phone, fax and e-mail address	304-348-1468 304-348-1411 shelmick@newwave.net	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title:

Sleep Lab

b. Location of proposal (Town including street address):

State of Connecticut / have not decided on city

c. List all the municipalities this project is intended to serve:

d. Estimated starting date for the project:

Aug. 1 2005e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E P

☐ ☐ Acute Care Hospital☐ ☐ Behavioral Health Provider☐ ☐ Hospital Affiliate

E P

☐ ☐ Imaging Center☐ ☐ Ambulatory Surgery Center☐ ☒ Other specify):

E P

☐ ☐ Cancer Center☐ ☐ Primary Care Clinic**SECTION III. EXPENDITURE INFORMATION**

a. Estimated Total Capital Expenditure/Cost:

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations	50,000
Medical Equipment (Purchase)	35,000
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	5,000
Sales Tax	
Delivery & Installation	500
Total Capital Expenditure	\$0.00 90,500.-
Fair Market Value of Leased Equipment	NA

Total Capital Cost	\$0.00
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Major Medical and/or imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Polysomnography	Nekar		2	15 to 20 K

Note: Provide copy of contract with vendor for medical equipment.

c. Type of financing or funding source:

- ☒ Operating Funds
 ☐ Lease Financing
 ☐ Conventional Loan
☐ Charitable Contributions
 ☐ CHEFA Financing
 ☐ Grant Funding
☐ Funded Depreciation
 ☐ Other (specify):

SECTION IV. PROPOSAL DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

SECTION V. AFFIDAVIT

Applicant: Professional Sleep Diagnostics, Inc.
 Project Title: Sleep Diagnostic Laboratory

I, SAM J. HELMICK, President
 (Name) (Position – CEO or CFO)

of Professional Sleep Diag. being duly sworn, depose and state that the
 information provided in this CON Determination form is true and accurate to the best of my
 knowledge, and that Professional Sleep Diag. complies with the appropriate
 (Facility Name)

and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-
 486 and/or 4-181 of the Connecticut General Statutes.

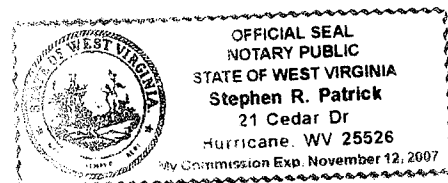
Sam J. Helmick
 Signature

6-2-05
 Date

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Subscribed and sworn to before me on JUNE - 2, 2005

[Signature]
 Notary Public/Commissioner of Superior Court



My commission expires: Nov. 12, 2007

SECTION IV. PROPOSAL DESCRIPTION

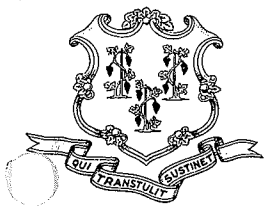
Professional Sleep Diagnostics, Inc. ("PSD") a West Virginia corporation established in 1988, proposes developing and operating a free-standing sleep diagnostic laboratory in the State of Connecticut. The lab(s) will provide polysomnography testing to identify individuals with sleep disorders.

1. We are currently not providing any services in the State of Connecticut. We are trying to determine if we need a certificate of need.
2. We will provide polysomnography testing. We do not believe any DPH licensure is required.
3. We will not be charging a facility fee.
4. The target population will be adult male and females that are referred to our lab to determine if they may have a sleep disorder.
5. PSD will provide these services with trained and licensed personnel.
6. Medicare, Medicaid and most commercial payers reimburse for sleep testing.

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STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

June 30, 2005

Sam J. Helmick
President
Professional Sleep Diagnostic, Inc.
112 Mellon Street
Beckley, WV 25801

RE: Certificate of Need Determination; Report Number 05-30525-DTR
Establish Sleep Lab
Professional Sleep Diagnostic, Inc.

Dear Mr. Helmick:

On June 3, 2005, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Determination request concerning the proposal of Professional Sleep Diagnostic, Inc. ("PSD") to establish sleep lab (s) in the State of Connecticut, at a total capital expenditure of \$90,500.

OHCA has reviewed the information contained in the request and makes the following findings:

1. PSD d/b/a Sleep Management Services is a for profit West Virginia corporation established in 1988.
2. PSD proposes to develop and operate a free-standing sleep diagnostic laboratory in the State of Connecticut.
3. PSD is a health care facility or institution as defined in Section 19a-630 of the Connecticut General Statutes ("C.G.S.").
4. PSD will provide polysomnography testing to identify individuals with sleep disorders.

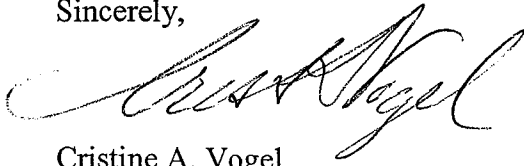
Based on the above findings, OHCA has determined Professional Sleep Diagnostic, Inc., a health care facility or institution, is required to seek and obtain Certificate of Need approval to establish sleep lab (s) in the State of Connecticut, pursuant to Section 19a-638 of the Connecticut General Statutes.

OHCA considers the submission of information received on June 3, 2005 as the Letter of Intent for this matter; therefore PSD may file a completed CON application with OHCA between

August 2, 2005, and October 1, 2005. The CON application is being mailed to your attention separately.

If you have any questions regarding the above, please contact Paolo Fiducia, Associate Health Care Analyst at (860) 418-7035.

Sincerely,



Cristine A. Vogel
Commissioner

Copy: Sandra Bauer, Health Processing Technician, DPH, DCBR